INDIANHILLS
COMMUNITY COLLEGE
Life. Changing.

Student Name (print)

Last Name: _____

First Name: _____

Middle Name: _____

Date of Birth (mm/dd/yy): _____

Student Medical History and Physical

This form MUST be completed and signed by a Health Care Provider (MD, DO, PA or ARNP) who is not a family member.	Date of Examination (mm/dd/yy)
Pulse:	**Blood Pressure:**
Allergies: ☐ Yes ☐ No	☐ Medications _____ ☐ Latex _____ ☐ Food _____ ☐ Other _____
Med-Alert Condition:	

Clinical Evaluation

	General Good Health	Fair Health Describe restrictions or concerns in space below by system.	Poor Health Describe restrictions or concerns in space below by system.
Neurological			
EENT			
Respiratory			
Cardiac			
Gastrointestinal			
Immunological			
Musculoskeletal			

Health Care Statement

I have examined: _____ **Date of Birth:** _____

Print Student's: Last Name First Name MI mm/dd/yy

☐ I find her/him physically able to participate in a Health Science Program at Indian Hills Community College and the student is in _____ health.
(Insert: good, fair, or poor)

HCP Name (print): _____ **HCP Title:** _____

Signature: _____ **Date:** _____

Please write Name and Address of Office/Clinic/Hospital

Indian Hills Community College Immunization Document

Student Name (print): _____ **Date of Birth (mm/dd/yy):** _____

This form is to be **completed, signed, and dated by a licensed health care provider (MD, DO, ARNP, PA) who is not a family member.** The HCP will determine what vaccinations or titers are indicated. Documentation of the items below are required by the clinical agencies Indian Hills Community College contracts with for clinical experience.

Vaccine	Vaccine Type	Date Given	Source
Diphtheria/Tetanus/ Pertussis Tdap Within past 10 years			
Measles, Rubella MMR 2 doses or positive titer for all 3 components			
Varicella 2 doses or positive antibody titer			
Hepatitis B 2 dose or 3 dose series depending on vaccine, or positive titer, or declination form			
Influenza Administered during current season Sept.-March, or declination form			
COVID 1 or 2 doses depending on vaccine, or declination form			
TB Skin Test 2-step series, or annual TB renewal after 2-step complete, or chest xray	**Date & Time Administered Lot # and Expiration Date**	**Date & Time Read**	**Results: mm & Signature Who Read Results**
#1 Skin Test			
#2 Skin Test Must be more than 7 days but less than 1 year between #1 and #2 skin test			
OR			
TB Renewal Due annually after 2-step TB complete			

I verify the information above is accurate and the above-named applicant has had the immunizations and TB test as indicated above or has laboratory evidence of positive antibody titer which is attached to this form.

HCP Name (print): _____

Signature: _____ **Date:** _____